The Need for Rural Systems in Prevention

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

THE NEED FOR RURAL SYSTEMS IN PREVENTION

November 2001

Submitted by:
COSMOS Corporation

Prepared for the
Office of Policy and Planning
Center for Substance Abuse Prevention
5515 Security Lane, 9th Floor
Rockville, MD 20852

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THE NEED FOR RURAL SYSTEMS IN PREVENTION

1. INTRODUCTION

Rural Americans represent a large proportion of the population with special needs and difficult circumstances. This paper provides background information and recommendations for policy makers and prevention practitioners as these professionals attempt to provide and deliver a system of prevention services in rural America.

Many factors contribute to rural Americans access to prevention services. For example, rural Americans must travel great distances for goods and services, and even then the availability and access is limited. Another complicating factor in rural areas is that technology is more difficult to install due to the costs associated with the distances. In addition, being a Native American or Alaskan native further complicates delivery of services due to cultural and sometimes political barriers (e.g., sovereign status). It also is important to note that among rural residents, only 1 in 20 is part of the farm population (U.S. Census, 1990). Rural Americans also have high rates of unemployment and those who are employed work in small businesses often at minimum wage. Families in Appalachia, for example, experience unemployment rates up to four times that of the country as a whole (Glasmeier and Fuelhart, 1999). There is a tremendous need to analyze assets and barriers in rural America and enhance the substance abuse prevention system that is responsive to the rural context.

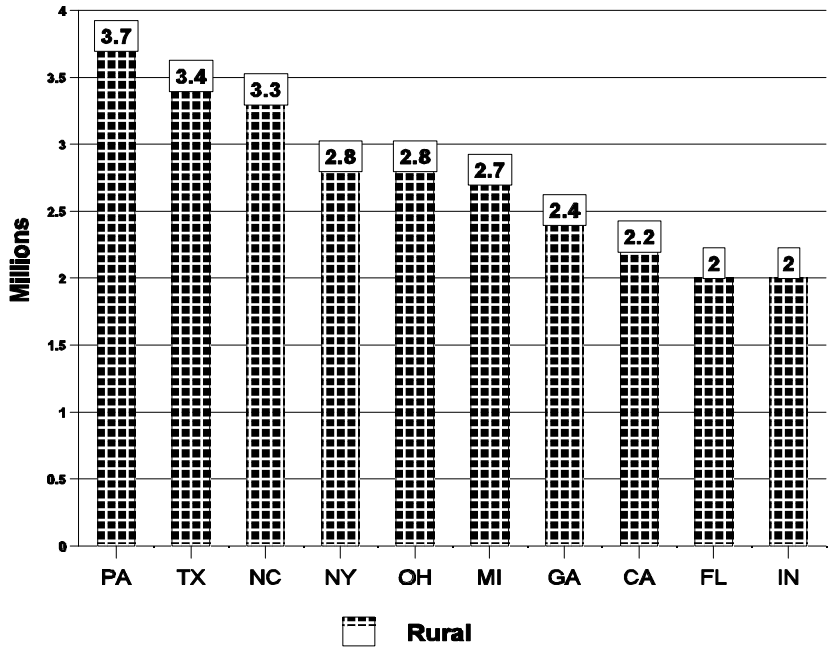
2. RURAL AMERICA

The only available data on rural populations (U.S. Census, 1990) indicated that one in four Americans lived in rural areas. The 2000 Census data regarding rural Americans will not be available until May-June of 2002, and the definition for rural is in the process of changing. The 2000 definitions view rural as areas with less than 500 persons per square mile regardless of boundaries. It is possible to live within the boundaries of large cities such as Phoenix, Arizona, and still be classified as rural because some cities have incorporated large areas of land that have fewer than 500 people per square mile. Technological advancements in the field of geographic information systems (GIS) over the last 10 years will allow the Census Bureau to automate the entire urban and rural delineation for the first time in Census Bureau history regardless of place boundaries.

Based on Census definitions (1990), Pennsylvania has the largest number of persons living in rural areas with 3.7 million rural residents (Exhibit 1). Texas ranked second in

Exhibit 1

TOP 10 STATES IN MILLIONS OF PERSONS LIVING IN RURAL AREAS



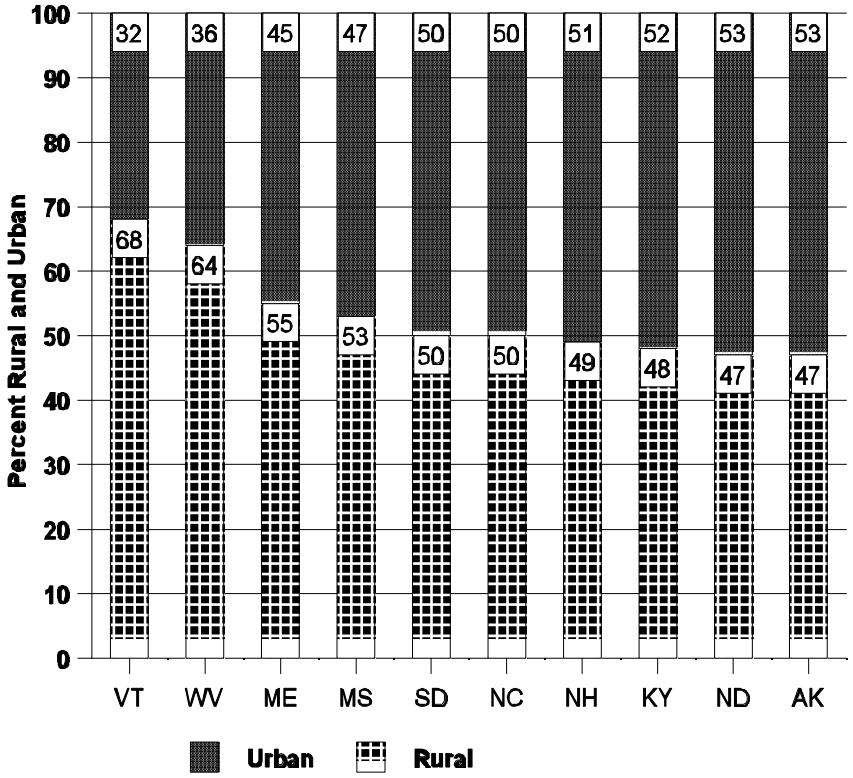
Source: U.S. Census, 1990

1990 with 3.4 million persons living in rural areas. The other States with the greatest numbers living in rural areas include States that are generally not perceived to be rural including New York, Ohio, California, and Florida. Seven States have 50 percent or more of their residents living in rural areas (Exhibit 2). Only North Carolina, with 3.3 million persons representing half of the State's population, is on both lists of top 10 States with persons living in rural areas.

Rural America is diverse along regional, cultural, and occupational lines with concentrations of Blacks in rural Southern States, Hispanics in rural Southwestern States, and Whites in rural Eastern and Midwestern States. Appalachia extends from South Carolina through Pennsylvania and has unique pockets of culture and social problems of long standing (Glasmeier and Fuellhart, 1999). Native Americans are most heavily concentrated on rural reservations west of the Mississippi river, but not exclusively there.

Exhibit 2

TOP 10 STATES IN PERCENT OF RURAL POPULATION



Source: U.S. Census, 1990

Migrant rural families are found throughout the United States in agricultural regions in which crops must be hand picked. Generally, rural America tends to be over represented by low income individuals.

Rural families are more likely to be extended families even if they are maternal in orientation with grandmothers raising their grandchildren while their own children are in school. It also is important to note that some rural residents commute significant distances to metropolitan areas for employment.

3. SUBSTANCE ABUSE IN RURAL AREAS

A myth persists that living in small towns in rural areas is a protective factor against substance abuse (Johnson, O'Malley, and Bachman 2000). Conversely, for several decades, rural youths and adults have had higher rates of alcohol and tobacco use than their urban counterparts. Furthermore, illicit drug use has become nearly equal resulting in the loss of an insulating value against illicit drug use in rural areas. It has been reported that rural teens have higher use rates of alcohol and tobacco than their urban counterparts (CASA, 2000). Rural adolescent use of anabolic steroids is similar to urban peers (Whitehead et al., 1992).

Rural students in grades 8, 10, and 12 are smoking more than their suburban and urban counterparts (Johnson, Bachman, and O'Malley, 2000) and this pattern of higher levels of smoking began around 1993 and has continued through 2000 (Exhibit 3).[1] While cigarette use went down for all populations from 1999 to 2000, it was still consistently higher in rural areas. According to the National Household Survey of Drug Abuse (Substance Abuse and Mental Health Services Administration, 2001), rates of cigarette use did not vary much by population density in 2000, they tended to be higher in less densely populated areas. In large metropolitan areas, 23.5 percent smoked in the past month, compared with 25.8 percent in small metropolitan areas and 26.9 percent in nonmetropolitan areas, and 27.4 percent in completely rural nonmetropolitan areas. Smoking rates showed more variation by population density among youths aged 12 to 17. For youths in large metropolitan areas, 11.6 percent smoked in the past month, compared with 17.6 percent of youths in completely rural nonmetropolitan areas. Cigarette smoking continues to be the number one cause of death in the United States and CSAP Model Programs have successfully prevented youths from starting in rural areas.

Based on data from *Monitoring the Future*, Cronk and Sarvela (1997) observed that rural youths used alcohol and tobacco more than urban or suburban youths and rural youths used illicit drugs (marijuana, LSD, amphetamines, cocaine, and inhalants) at the same rates as other youths. In 2000, NHSDA (Substance Abuse and Mental Health Services Administration, 2001) reported lower levels of alcohol use among rural youths. Underage current alcohol use rates were similar in large metropolitan areas (26.5%), small metropolitan areas (28.8%), and nonmetropolitan areas (27.7%), but the rate in nonmetropolitan rural areas was the lowest at 24.5 percent. More recently, Johnson, O'Malley, and Bachman (2000) concluded that rural youths were no longer protected by their environments and that parents in all areas should be concerned about illicit drug use.

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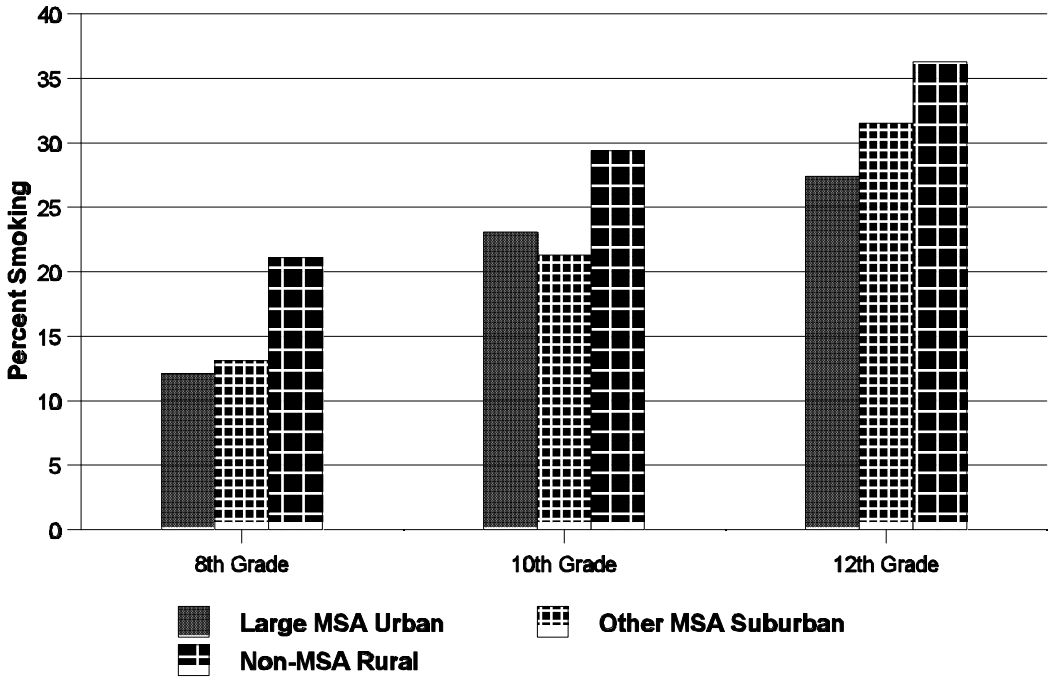
[1] In Exhibit 3, MSA refers to Metropolitan Standard Area with large MSAs being the 16 largest urban areas, other MSAs being suburban areas of 50,000 or more, and non-MSAs representing rural areas of less than 50,000.

Exhibit 3

TRENDS IN 30-DAY SMOKING BY POPULATION DENSITY



Source: Johnson, Bachman, and O'Malley, 2000

"There have not been very large or consistent differences in overall illicit drug use associated with population density over the life of the study, which helps to demonstrate just how ubiquitous the illicit drug phenomenon has been in this country. In the last few years, the use of a number of drugs has declined more in the urban areas than in the non-urban ones leaving the non-urban area with higher rates of use. The upsurge in ecstasy use in 1999 was largely concentrated in urban areas, but in 2000 use increased in communities of all sizes. Crack and heroin use are not concentrated in urban areas, as is commonly thought, meaning that no parent should assume their youngsters are immune to these threats simply because they do not live in a city." (Johnson, Bachman, and O'Malley, 2000).

Conversely, while NHSDA (Substance Abuse and Mental Health Services Administration, 2001) reported the overall rate of illicit drug use for any age in metropolitan areas was higher than the rate in nonmetropolitan areas. Rates were 6.5 percent in large metropolitan areas, 6.7 percent in small metropolitan areas, 5.1 percent in nonmetropolitan areas and 3.9 percent in completely rural counties, and 4.5 percent in less urbanized nonmetropolitan counties. Among youth in 2000, rates of any illicit drug use were similar across county types. Rates ranged from 8.0 percent in less urbanized nonmetropolitan counties to 11.5 percent in urbanized nonmetropolitan counties

A telephone survey was used to obtain information from a representative sample of 8,913 rural school districts in the U.S. (U.S. Government Accounting Office, 1992). Student drug use in rural areas was found to be a problem, with rural students using alcohol and other drugs at rates similar to students in urban and suburban areas. Most rural school districts are implementing multifaceted programs to combat the school drug problem. Many also provide training for teachers and programs to educate and involve parents and others in the community. But most districts see a need to increase their efforts, especially student intervention services and programs to educate and involve parents or others in the community. Drug Free Schools grants are the primary source of drug education and prevention funding in over 50 percent of all rural school districts. Overall, 86 percent of rural districts received Drug Free Schools funds for school year 1990-1991, and about 66 percent of these paid for over 50 percent of their drug education programs with these funds. Nearly all districts use funds from other sources to help meet their drug education and prevention needs (U.S. Government Accounting Office, 1992).

4. ISSUES IN RURAL PREVENTION SYSTEMS SERVICE DELIVERY

The health care service delivery system is different in rural areas that have fewer managed care organizations available, fewer medical providers, and even fewer substance abuse treatment resources. Furthermore, highly specialized services are simply not available due to the lack of economies of scale. Also, coordination among geographically dispersed agencies is logistically more difficult. Small town and rural boundaries based on family and community traditions prevent coordination and collaboration across those sometimes unseen boundaries. These same boundaries slowed the consolidation of rural school districts and are confronted by any service delivery system. School districts remain fiercely independent and difficult to access for some prevention providers yet they are the primary social agency involving youths. Other resources, such as 4-H clubs and Agricultural Extension have not been systematically mobilized to provide prevention services. A notable exception to the underutilization of agricultural extension agents is St. Pierre (1999) who has been systematically evaluating a prevention program delivered by these professionals.

People in rural or urban environments face barriers to accessing prevention services, but rural barriers sometimes are greater in their absence. For example, lack of public transportation is a barrier in rural and urban areas, but in a rural context this barrier is compounded by the great distances involved. Bushy (1994) listed the following as barriers to primary prevention services in rural areas.

- Great distances;
- Lack of public transportation;
- Lack of telephone services;
- Lack of outreach services;
- Inequitable reimbursement policies; and
- Unpredictable weather conditions.

In addition to accessing services, Bushy (1994) also identified issues around the acceptability of prevention services by the proposed recipients. Views about how individuals living in rural areas should handle personal problems vary, beliefs about the cause and cure of a problem also may be at odds with providers, lack of knowledge about the effects of alcohol, tobacco and illicit drug use, and confidentiality and anonymity are more difficult to assure in an environment where people are well known.

Lack of coordination among service providers also is a common problem in rural areas. Agencies are separated by great distances which reduces formal and informal communication (Conrad, 1991). In a CSAP Pregnancy and Postpartum Women and Infants (PPWI) project, Vicary et al., (1996) assisted with forming a coordinating group that consisted of 35 different social service agencies all of whom had some responsibility for pregnant women and teenagers, infants, child welfare, substance abuse, and education. These agencies came from an area encompassing 250 square miles and driving time across this area was approximately two hours. The minimum driving time for substance abuse services was one hour from the center of this area to the county seat. The prevention specialist for this area also was housed in the county government offices. Many of these agencies did not know the others existed, and as a result of the demonstration grant, they began regular formal and informal communication that resulted in improved services to all the clients in the region (Gurgevich, 1995) and reduced alcohol use during pregnancy (Vicary et al., 1996).

Problems arising from rural area's distances are not unique to any one part of the country and in fact are probably greater in the West and Southwest. Travel time and

milage would be needed to help break down these barriers, as well as, increasing the ability of prevention providers to use technology and to increase the infrastructure to make technology more available.

The identification and support of key stakeholders in rural areas is more difficult because of the great distances, but also more important in order to achieve cooperation. Schools are often the major prevention provider in rural areas, and the administrator, teachers, and school boards must be involved as part of planning for a prevention program (Metz, 1995). A separate study within the Northland Project, (Rissel et al., 1995), identified factors that influence participation of community members and parents in prevention task forces. They concluded that task forces should maximize the members' perceptions of ownership and control and involve members who have been longtime residents in their communities. These conclusions were based on an empirical comparison of the members of 10 rural task forces. Furthermore, their findings are consistent with the dynamics of distrust of outsiders and the lower rate of mobility among rural residences (Scaramella, 2000).

Confidentiality and privacy issues are more difficult in rural areas because of the general lack of anonymity. This is both a barrier and an asset. Youths in rural areas are known by the other residents and easily recognized. The lack of anonymity results in youths being more easily monitored by informal networks of adults. Teachers in rural areas are more likely to be neighbors along with mental health and substance abuse service providers. Conversely, Rissel et al., (1995), reported some members dropping out of task forces because they knew and did not like other members. While this can happen in urban areas, it far more likely to happen in rural areas.

Growing competition and effective law enforcement efforts in large cities have forced drug manufacturers to relocate production facilities to remote areas to evade detection and to exploit potential consumer pools. Marijuana growers and methcathinone and methamphetamine manufacturers are taking advantage of the isolation offered by rural environments to produce illegal drugs. Crack cocaine dealers also are looking for customers in the less hostile rural environments. Rural areas are ill equipped to manage the rapid increase of drug distribution and abuse and the resulting health and social problems (O'Dea, 1997).

Special populations and regions create unique barriers to the delivery of prevention services. Native American youths are only accessible through permission of the tribal councils. These governing bodies have little confidence in "White" solutions to their problems (Harris et al., 1988). Vega, et al., (1998) described illicit drug use among Mexicans and Mexican Americans as a dynamic changing problem due to the acculturation of these minorities into the mainstream culture. Segal (1994) described Alaskan youths as more vulnerable to ATOD use due to their isolation and "last frontier" mentality. The

isolation of some youths in Alaska makes them both more immune, but more susceptible to local fads. Albrech et al., (1996) highlighted the lack of research on Blacks living in rural areas in geographic regions of Southern States. Albrech et al., (1996) found that families and churches played an important protective role in these communities. In addition to the unique needs of various racial and ethnic minorities, there is a problem of providing specialized adapted services to very small numbers of minorities geographically dispersed within a particular area. For example, a rural community of several hundred square miles may have minority residents who are scattered throughout the region thereby making it more difficult to provide specialized service.

5. CSAP'S MODEL PROGRAM FOR RURAL COMMUNITIES

CSAP has identified several domains that provide an audience or context for delivery of prevention services. These domains include the individual, peer groups, families, schools, communities, and the larger society. These domains were derived from the nested ecological model, first developed by Bronfenbrenner (1979) to explain human behavior in the context of larger systems in which the individual functions. This model also allows for an understanding of how domains interact with each other. For example, families impact their schools while at the same time the school is impacting families. Similarly, peers affect individuals while individuals influence their peer group.

The concept of "nested" interconnected domains or systems provides a framework for viewing the rural substance abuse prevention programs as attempts to systematically alter and restructure existing ecological systems in ways that challenge the forms of social organization, belief systems and lifestyles prevailing in rural areas. It is important for prevention providers to recognize that the domains listed above function differently in a rural context and these differences must be understood and engaged in each community before a comprehensive program will be adopted by a community.

Barriers Experienced by CSAP Model Programs

The model programs described in Section 5 were contacted regarding barriers they encountered and strategies they used to overcome these barriers. An initial list of barriers based on Bushy (1994) was used to trigger ideas and discussions. The major groupings of barriers that resulted from these contacts were logistical, technological, fiscal policies, and cultural.

Logistical barriers were common to all model programs and included great distances, weather conditions, and lack of public transportation. There were several strategies used to manage these problems including:

- Allowing for more time for trainers or clients to get to sessions;
- Not scheduling meeting at certain times of the year and setting alternative dates in advance;
- Paying for the travel time and expenses of staff;
- Obtaining supplemental funds for transportation of clients and staff; and
- Providing alternative transportation.

One program was particularly successful in obtaining grants from other sources which resulted in the purchase of a van to transport staff and clients to program sessions. Another program budgeted travel monies for teachers to help them attend training. One model program also paid staff for their travel time involved in accessing some remote areas. In locations where extreme weather was a factor, programs avoided those time periods or simply planned alternate "snow" dates in advance. There was a pervasive attitude that program personnel needed to be flexible in their planning in order to adjust to the logistical barriers frequently encountered in rural areas. However, many of the solutions to these barriers required additional funds either in their original grants or in their operating budgets.

The extent of technological barriers was more varied. Some model programs did not experience problems due to lack of telephone service, lack of computers, or lack of Internet access. Others reported these as problems and used networks of friends and neighbors to share telephones or improve communication. Some programs bought computers for agencies while others simply worked with print versions of materials and avoided any required access to computers. There is a need to increase the number of schools that have access to the Internet and to upgrade the computer skills of agency personnel attempting to deliver prevention programs in rural areas.

The fiscal policies that several model programs encountered centered around the low levels of funding received by rural schools and community agencies due to State and federal formulas that are based on populations. The obvious consequence is that the smaller numbers of persons in rural areas result in lower levels of funding, but as noted above, providing and accessing services is actually more expensive. One model program helped schools form a consortium that pooled their resources and thereby enabling them to obtain sufficient funds for training and materials. Another program supplied the student materials free of cost and another model program had other funding that allows it to provide training at greatly reduced costs.

One cultural barrier that some model programs encountered was the myth that rural areas do not have the drug problems that urban areas experience. The data clearly indicate that rural youths smoke and drink more than their urban counterparts. Rural youths also use other illicit drugs the same as urban and suburban youths (Johnson, Bachman, and O'Malley, 2000). A related cultural barrier encountered by model programs was the involvement of community members in growing of tobacco and marijuana. Obviously, there are legal issues with growing marijuana, but tobacco growing is a major source of legitimate income in some rural areas. Rural farmers can usually make more money from their acreage growing tobacco than any other farm use of their land. The solutions to overcoming this type of barrier were to accept this farm activity as legitimate and agree among the community members that smoking by youths was unacceptable. Some model programs also encountered community members that wanted to use the coalition as a forum for advocating the legalization of marijuana. These programs simple indicated that such an issue was not within the scope of the coalition's purposes.

Another cultural barrier experienced by several model programs was the difficulty of maintaining confidentiality and anonymity. Rural residents often know everyone and it is difficult to maintain certain privacies. One model program found that it was very important for agency personnel, community members, and youths to agree at the outset to not disclose their own behaviors or the behavior of others. This program reported more casual attitudes about confidentiality in rural areas compared to other areas in which they work. If someone in a group has a problem, he or she is instructed to talk with the group leader privately after a program session or meeting. Another model program uses outside research assistants to collect survey data in order for the students to have a degree of anonymity during testing.

Some rural areas also experienced problems with nearby leisure centers. These resort areas tend to have higher levels of use of all licit and illicit substances, and it was important for the model programs to acknowledge these problems and assist in offsetting the cultural impact of resorts on youths without undermining the economic benefits to the community. In these contexts, model programs found it more important to establish a greater awareness of accurate normative behavior versus the typical behavior of persons in resorts and at the same time to involve resort stakeholders in the coalitions. A similar problem was encountered in rural areas where a college was present. In these instances, it was important for the college leadership to be part of a community-wide effort to provide prevention services. In some instances, college students participated in prevention service delivery and thereby modeled positive behavior for youths in the community.

Finally, rural model programs are more likely to be involved with Native American tribes and related agencies and the cultural differences in each. In these instances, model programs worked with key leaders among the tribes and facilitated the adaptation to their materials to reflect the values of the tribes involved. However, one model program

emphasized that they maintained underlying principles of prevention while the context of the materials were altered. Just as school boards need to approve programs and activities for their communities, Native American councils need to approve programs that attempt to reach members of their communities.

CSAP's "2001 Annual Report of Science-Based Prevention Programs" identifies programs that work in rural areas (CSAP, 2001). These model programs had to meet high standards for their evaluation designs and results. All of them had positive results in reducing alcohol, tobacco, and other drug use as well as success in reducing risk factors and enhancing resiliency factors. The vast majority of these programs did not name the rural communities in which the evaluations took place, often as part of a human subjects approval to maintain confidentiality and anonymity. The Web site for more complete information is:

http://www.samhsa.gov/csap/modelprograms/

Each program also is classified according to the Institute of Medicine's (IOM) three types of prevention including:

- ***Universal preventive*** interventions are activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk;

- ***Indicated preventive*** interventions are activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels; and

- ***Selective preventive*** interventions are activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

5.1 Child Development Project (Universal)

The Child Development Project was a five-year initiative designed as a comprehensive school-based program to reduce risk and bolster protective factors related to substance use. The effort attempted to transform the school into a "Community of Caring" in which a student's intrinsic motivation to learn was nurtured. Supportive social relationships, sense of common purpose, and a commitment to pro-social values responsive to children's developmental needs were commonplace. The primary intervention activities

cited to accomplish these objectives included: 1) learning in a cooperative classroom; 2) implementing "values rich" literature-based reading and language arts programs; 3) establishing a developmental discipline program and classroom management plan with input from the students vis-à-vis appropriate behavioral contingencies; 4) developing classroom and school-community building projects that fostered cooperation and communication between teachers, students, and families; and 5) conducting home activities in which youths and families work together to develop classroom presentations.

5.2 Communities Mobilizing for Change on Alcohol (CMCA) (Universal)

CMCA is a community organizing effort designed to change policies and practices of major community institutions in ways that reduce access to alcohol by teenagers. CMCA was developed and evaluated in a 15-community randomized trial by the Alcohol Epidemiology Program at the University of Minnesota School of Public Health, under the direction of Professor Alexander C. Wagenaar. The intervention approach involves activating the citizenry of communities to achieve changes in local public policies and changes in the practices of major community institutions, such as law enforcement, licensing departments, community events, civic groups, churches and synagogues, schools, and local mass media. The objective is to reduce the flow of alcohol to youths from illegal sales by retail establishments and from provision of alcohol to youths by other adults in the community.

5.3 Positive Action (Universal)

The Positive Action Program is a systematic, comprehensive program that uses research-proven strategies and methods such as active learning, positive classroom management, a detailed curriculum with lessons given daily, a school wide climate program, parent support and involvement, and community involvement. The program is based on the philosophy that "you feel good about yourself when you do positive actions." The program aligns school, parent, and community components in which specific positive actions are taught in the physical, intellectual, and social/emotional areas. The program is guided by the principal with the assistance of a coordinator and a committee. The curriculum is taught by all the classroom teachers 15 minutes a day, 4 days a week, using a grade-appropriate kit containing a manual with all the lesson plans and materials. The school climate program involves everyone in the school, reinforcing positive actions they observe throughout the school day. The program has been shown to improve a wide range of behaviors including reduced substance use, violence, disruptive behavior, and improved academic achievement.

5.4 Project ALERT (Universal)

Project ALERT is a school-based, social resistance approach to drug abuse prevention. The curriculum specifically targets cigarettes, alcohol, and marijuana use. Objectives enable students to: 1) develop reasons not to use drugs; 2) identify pressures to use them; 3) counter pro-drug messages; 4) learn how to say no to external and internal pressures; 5) understand that most people do not use drugs; and 6) recognize the benefits of resistance. Project ALERT is a video-based curriculum designed for students in grades six and seven or seven and eight. The first year's program consists of eight lessons, taught a week apart. These lessons are reinforced during three additional lessons in the second year of the program. The highly participatory curriculum makes extensive use of questions-and-answer techniques, small-group exercises, role modeling, and repeated skills practice. These methods allow teachers to adjust program content to diverse classrooms with different levels of information and drug exposure.

5.5 Project Northland (Universal)

The goal of Project Northland is to prevent or reduce alcohol use among young adolescents by using a multilevel, community-wide approach. Project Northland was evaluated in 24 communities and school districts in rural northeastern Minnesota since 1991, the intervention targeted the class of 1998 (sixth-grade students in 1991). The program consists of: 1) social-behavioral curricula in schools; 2) peer leadership (designed to increase peer pressure resistance and social competence skills); 3) parental involvement/ education (to provide parental support and modeling); and 4) communitywide task force activities (designed to change the larger environment). Project Northland also has been successfully extended to include the senior high school students.

5.6 Life Skills Training (Universal)

Life Skills Training (LST) is a classroom-based substance abuse prevention program tested at Cornell University's Institute for Prevention Research. LST is highly effective with 10- to 14-year-old middle school and junior high school students. It has been tested and proven to be effective with White, African American, and Latino youths, and was recently evaluated in nine rural Pennsylvania communities. LST is designed to be implemented in any school setting throughout the United States and is now being developed for communities abroad. By teaching students personal and social skills in order to promote individual competence, LST aims to decrease young people's vulnerability to pro-substance use social influences from peers and the media. Results show that the program significantly reduces tobacco, alcohol, and marijuana use.

5.7 Project Venture (Universal)

Project Venture is a comprehensive prevention program working with American Indian youths from three Pueblo communities and one Navajo community in New Mexico.

Using an habilitation service leadership model, the program combines a summer camp and follow-up intergenerational activities designed to increase skills, self-efficiency and community bonding in youths aged nine to 13. The major intervention strategies include: 1) summer skill-building leadership camps; 2) school- and community-based programs; and 3) intertribal activities and training opportunities for youths, parents, school staff, and service providers. The activities are designed to develop skills and self confidence, build group problem-solving strategies, build a sense of the power of teamwork, cooperation, and trust.

5.8 The Strengthening Families Program (Indicated)

Strengthening Families Program (SFP) targets the families of children age six through 11 who are at risk of substance abuse. The program focuses on family attachment and bonding, family supervision, family communication of values, and no drug use expectations. SFP interventions consist of parent training, social and life skills training curriculums for elementary-aged children, and family practice sessions. In general, children showed decreased impulsivity, improved behavior at home, improved sibling relationships, and decreased use of and intent to use tobacco, alcohol, and illicit drugs. Parents reported significantly decreased drug use, stress, depression, and use of corporal punishment. Increased parental efficacy, ability to plan family-oriented activities, clarity of rules, and decreased social isolation of parents also were found.

5.9 Creating Lasting Connections (Indicated)

Creating Lasting Connections (CLC) was designed to: 1) work with both community and family systems to identify youths and parents/guardians at high-risk for AOD (alcohol/other drug) use; 2) increase familial resilience to and decrease risk for AOD use; 3) provide/refer families in need to appropriate social service agencies; and 4) mobilize communities to prevent AOD use. Because churches already foster natural support systems, they were identified as the pivotal community agency from which to implement this culturally competent/appropriate early intervention program for high-risk youths age 11 to 15 and their families.

5.10 Dare To Be You (Selected)

The Dare To Be You program was a five-year grant initiated in 1989 that targeted preschool youths ages two to five and their families. The project was implemented in four ethnically diverse sites across Colorado and included the: 1) Ute Mountain community (95% Native American and rural); 2) San Luis Valley (64% Hispanic and rural); 3) Colorado Springs (53% European American and urban); and 4) Montezuma County (84% European American and suburban). The demonstration project was designed to work directly with parents to increase their knowledge of: 1) child development;

2) personal sense of worth; 3) ability to effectively manage their children (by increasing their communication and problem solving skills); and 4) knowledge and use of appropriate child-rearing practices (thereby enhancing the home environment and imbuing youths with the ability to later resist the lure of substance use). In tandem with the parent training program, trained staff also worked directly with youths attempting to bolster their sense of self-worth, as well as improve their communication and reasoning skills. By bolstering these key resiliency factors, the program hoped to prevent later substance use.

5.11 Nurse Family Partnership (Selected)

The Prenatal/Early Infancy Project is a comprehensive project targeting young, unmarried mothers in a semi-rural Appalachian region of New York that had high rates of poverty and child abuse. The project included multiple interventions, such as home visitations by a nurse from pregnancy through age two, health education for parents, job and educational counseling, parent training, and social service linkages through referral and advocacy systems. Home visitors encouraged close friends and family members to participate in the home visits and to help mothers with child care and household responsibilities. The prenatal and infant health care component of the program involved screening and referral, home visits every two weeks during pregnancy, free transportation to well-child care clinics, and continued nurse visitation until the children were two years old. Registered nurses, who had participated in a three-month training program, worked in two-person teams to deliver the program.

Exhibit 4 presents a summary of CSAP's Rural Model Programs by the domains they cover.

Exhibit 4

RURAL MODEL PROGRAMS AND DOMAINS COVERED

Rural Model Programs	CSAP Domains				
	Individual	Peer	Family	School	Community
ALERT (Universal)	▲----------				
Life Skills Training (Universal)	▲---------- ----------				
Strengthening Families (Selected)	▲----------]		[----------▲		
Nurse Family Partnership (Selected)	▲----------]		[----------▲		
Creating Lasting Connections (Indicated)	▲----------]		[----------▲		
Dare To Be You (Selected)	▲----------]		[----------▲		
Child Development Project (Universal)	▲---------- ---------- ---------- ---------- - ▲				
Communities Mobilizing for Change on Alcohol				▲--------- ▲	
Project Venture (Universal)	▲---------- ----------				
Positive Action (Universal)	▲---------- ----------				

Project Northland	▲---------- ----------				

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